"...accidents in complex systems only occur because of multiple small factors or failures, each necessary but only jointly sufficient to produce the accident. These small failures or vulnerabilities are present in the organization long before a specific incident is triggered."

—David Woods
Institute for Ergonomics
Ohio State University,
May 15, 1998

A New Way of Thinking for Patient Safety Improvement...

- Reduces the likelihood that care results in harmful patient outcomes.
- Encourages complete reporting of adverse events and other patient safety information.
- Provides optimal validity and credibility in the review of events and analysis of system issues.
- Promotes learning lessons from the broadest possible pool of healthcare providers.
- Supports rapid public dissemination of patient safety lessons learned.

We Have...

- A risk management program that encourages open reporting of untoward outcomes.
- An atmosphere that encourages complete reporting.
- To create a culture that permits medical care personnel to acknowledge the occurrence of error and encourages open and complete reporting of adverse events.

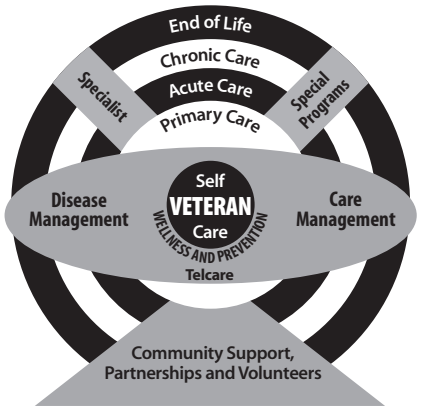
To View Lessons Learned:

Access the Internet at this address:

http://www.va.gov/visns/visn02/vitalsigns/patientsafety.html

You may also link to the National Patient Safety Foundation (NPSF) site from our website, or directly access at the following address:

http://www.npsf.org/



Integrated Patient Safety/ Risk Management Program

Providing a team effort towards a high-reliability healthcare system

VA HEALTHCARE NETWORK UPSTATE NEW YORK

"Better Care Through Better Reporting"

Policy

In an effort to assure uniform high performance, a Network Integrated Patient Safety/Risk Management Program (Memorandum No. 02-98-29) was developed, rescinding all local Risk Management policies. This policy was developed by the Risk Management Team, made up of local representatives from Risk Management and Safety. It includes clinical as well as environmental issues. Ask your supervisor for a copy of the completed policy or look it up on the Network 2 Website:

http://www.va.gov/visns/visn02/vitalsigns/patientsafety.html

If you have questions regarding this policy you should contact your local Risk Manager listed below:

Albany: Barbara Parker
(518) 462-3311, x2799

Bath: Robert Jeffery
(607) 776-2111, x3013

Buffalo: Gloria Stanz
(716) 862-8819

Canandaigua: Sharon Courtney
(716) 393-7575

Syracuse: Marcia Dawley
(315) 476-7461, x3929

N2 Risk Manager: Suzanne LeGrett
(716) 393-7578

Reporting Considerations

Unplanned Clinical Occurrence:

An adverse event that results in hospitalization or increased length of stay, or that more than likely, without intervention, would have resulted in a sentinel event.

Environment of Care Incidents:

An Environment of Care Incident is a high-risk event that did not necessarily involve a patient, it may involve employees, visitors, utility failures, or, property damage such as a fire.

Sentinel Event:

- Hemolytic blood transfusion reaction involving major blood group incompatibilities
- Surgery on wrong patient or body part
- Unanticipated death or major permanent loss of function not related to natural cause of the patient's illness or underlying condition.
- Rape (patient or staff)
- Any patient death, paralysis, coma or other major permanent loss of function from a medication error.

Root Cause Analysis

In an effort to "weed" out those factors that are present that make our organization vulnerable Root Cause Analysis will be conducted.

- Identifies the causal factor(s) that underlie variation in performance including the occurrence of a sentinel event.
- Focuses primarily on systems and processes, not individual performances.
- Searches for special causes in clinical processes.
- Seeks to "design out" system failures.

Reporting an event is non-punitive. You are encouraged to report an event or "near miss" to Risk Management. Over reporting is better than under reporting. Through this collaborative venture we, as a Network, can create a better and safer environment for our community.

"Better Care Through Better Knowledge"